|  Health ServicesWalla Walla Public Schools 614 S. 3rd Ave. Walla Walla, WA 99362 |  CHECK ONE:☐ Original Request ☐ Extension NOTE: Beginning date on extension requested must consecutively follow the ending date of original request. |
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| **STUDENT INFORMATION** |
| Student Name: (last, first, middle initial) PLEASE PRINT | School Where Student is Enrolled | Grade Level: |
| Student’s Parents/Guardian’s Name: | Telephone Number: | Enrolled in Special Education? ☐ Yes ☐ No  | Gender? |
| **SECTION 1 - TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER** |
| DIAGNOSIS:☐ Disease/Injury/surgery (specify primary diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Pregnancy (give due date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Post-Partum (give delivery date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* **I certify that this student is physically unable to attend school because of their own medical condition for \_\_\_\_\_\_\_\_\_\_\_\_\_ weeks starting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**
* **I certify that this student is physically unable to attend school because of their pregnancy starting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and continuing for \_\_\_\_\_\_\_\_\_\_\_ weeks due to their medical condition.\***
* **I certify that this student is physically unable to attend school for \_\_\_\_\_\_\_ week’s post-partum due to their own medical condition.\***

\* Call school or tutor with delivery date. If delivery or recovery is complicated and more recovery time is needed, submit an extension for longer service. |
| Name of Provider: | Telephone number: | Business Address:  |
| Signature: | Date: |
| **SECTION 2 - FOR SCHOOL DISTRICT USE** |
| Tutor’s name: | Telephone number: | School contact: | Position: |
| Reviewed by: | Date: | Start date: \_\_\_\_\_\_\_\_\_# of Weeks: \_\_\_\_\_\_\_\_ | ☐ Approved☐ Denied |
| Questions? Call Health Services: 509-526-8507  |